The Oregon Health Plan (OHP), the State of Oregon's Section 1115 Health Care Reform Demonstration, has garnered national attention for its path-breaking use of capitated managed care, and of a prioritized list of health care services to define the program's benefit package. Program savings from these reforms were used to expand eligibility to cover uninsured residents below the Federal Poverty Level (FPL), regardless of whether they meet traditional categorical Medicaid eligibility requirements.
The Centers for Medicare & Medicaid Services (then the Health Care Financing Administration) contracted with Health Economics Research, Inc. to conduct a comprehensive evaluation of OHP. The following is a summary of key findings from their evaluation of Phase I of OHP. Phase I, implemented in February 1994, introduced the expansion of eligibility; mandatory enrollment in (primarily capitated) managed care for AFDC recipients, poverty-level pregnant women and children and the expansion population; and the prioritized list of services. These evaluation findings pertain to the first six years of OHP implementation, from 1994 through 1999.

Eligibility Expansion

- Enrollment Trends: Initially, the growth of the newly eligible population exceeded all projections, increasing to 134,000 by October 1995. At its peak, the expansion population constituted one-third of all Medicaid eligibles in Oregon. Following changes to program eligibility and administrative rules designed to restrict eligibility, expansion enrollment began to decline, reaching 81,000 in January 1999. OHP has been effective in providing health insurance to low income Oregonians; nevertheless, in 1998 23 percent of the population living below poverty remained without health insurance.
- Impact of Expansion on Traditional Eligibles: No significant differences were found between care received by traditional and expansion eligibles. Oregon has succeeded in covering a large additional population through their eligibility expansion without compromising care for existing Medicaid eligibles.
- Adverse Selection into OHP: Evidence suggests that there was adverse selection into the OHP expansion population. Expansion beneficiaries had poorer health status on average than uninsured members of a low-income comparison group, and were more likely to report a disability that prevented them from working. Focus group interviews revealed that expansion eligibles often signed up for OHP when they had an immediate need for health services, and then dropped coverage once the need had passed. The lack of pre-existing condition exclusions in OHP partly accounts for this outcome.
- Expansion Population Rate Setting Issues: Setting capitation rates for newly covered populations has been a challenge. Oregon found that coverage for expansion eligibles was more expensive than anticipated. Other states covering similar populations through eligibility expansions will need to carefully consider the appropriate base for setting capitation payments and will need to monitor plan experience with these groups.
- No Evidence of Crowd-Out: Crowd-out of private insurance does not appear to be a major problem for OHP. Few expansion beneficiaries had access to employer-based health insurance, and the vast majority were uninsured before joining OHP. Of those who were insured by an employer prior to joining OHP, only 27 percent

(4 percent of expansion enrollees) enrolled because their employer dropped coverage.

- Premiums: Coverage of expansion beneficiaries became increasingly episodic and churning of the enrolled population increased after the State introduced premiums for the adult expansion population in late 1995. Imposition of premiums on adults did not have any significant spill-over effect on children's participation in OHP. Premiums on expansion eligibles provide only a small amount of support for the program, representing only 1.2 percent of the state's biennial OHP spending and just 4.8 percent of state spending on the expansion population.

Managed Care

- Increased Use of Capitated Managed Care: One of the key features of OHP was a commitment to enroll the eligible population into managed care "where feasible." By December 1996, Oregon had enrolled 82 percent of Medicaid eligibles in capitated managed care. Oregon has succeeded in creating a statewide managed care delivery system, with contracting plans in all but two of the State's 36 counties (as of December 1997), up from only 8 counties in 1993. OHP managed care had a spill-over effect on private health insurance, introducing managed care to areas of the State it had not penetrated before.
- Managed Care and Access and Quality: Evidence concerning the effects of capitated managed care on access to care and quality of care was mixed. Non-disabled adults enrolled in OHP, virtually all of whom were enrolled in managed care, were more likely to have a usual source of care or receive a Pap test than comparable low-income adults with private insurance. (Ninety-seven percent of adult OHP members surveyed were in managed care, compared to less than 54 percent with private insurance (1.04, page 27). Corresponding percentages of children in managed care were 94 percent for OHP and 62 percent for privately insured, respectively.) Children with asthma in managed care were more likely to receive standard care than their counterparts in fee-for-service Medicaid. On the other hand, both adults and children in OHP were more likely to report unmet need for prescription drugs than those with private insurance, with OHP members citing plan or primary care provider refusal to provide the service as the most commonly given reason. OHP children were significantly less likely to have seen a specialist than privately insured children, but no more likely to have unmet need for specialist care.
- Satisfaction: OHP members reported greater overall satisfaction with their quality of care and depth of insurance coverage than both insured and uninsured members of the low-income comparison group.
- Managed Care Rate Setting: During the first six years of OHP, the State made several adjustments to their methods for setting payment rates for fully capitated health plans. Significant issues included defining reasonable, internally homogeneous rate cell categories; finding appropriate utilization data for rate setting, especially for groups moving into managed care or for whom there was no prior claims experience; developing and using encounter data when pre-OHP claims-based utilization data became out-dated and eventual implementation of risk adjustment.

- Increased Use of Medicaid-Only Plans: As OHP developed, the mix of health plans changed, with local physician-sponsored plans becoming increasingly important, particularly in rural areas. Their growing importance, along with the departure of several commercial plans, increased OHP's reliance on "non-mainstream" plans that either were initially formed to contract with OHP or enroll only Medicaid eligibles.

Priority List

- Priority List and Access: One quarter of Phase I adults reported that OHP had refused to pay for a treatment they needed. Forty-two percent of these denials were because the treatment was "below the line." About one-third of OHP respondents with below-the-line denials said that they had gotten the service anyway, usually by paying for it themselves. Of those who did not get the service, two-thirds said that their health had gotten worse as a result. Similar results were reported for children, albeit with lower rates of service denials.
- Priority List and Quality of Care: OHP members with low back pain, a below-the-line condition, fared worse than those with above the line conditions, although the difference could be due to natural disease progression rather than denial of care due to the priority list. Further investigation is warranted.
- Priority List and Cost Containment: The priority list has had limited usefulness as a cost-containment tool. Since the beginning of OHP, the funding line has been raised twice in response to budget pressures. In both cases, the change in the funding line generated only a fraction of the savings needed. Further adjustments are unlikely as they would eliminate coverage for essential services, and probably would not be approved by HCFA. The priority list must be updated continuously to reflect changes in medical technology, a high maintenance effort that individual states may not be willing to make.

Effect of OHP on Providers

- Physicians: Physician participation in OHP is high, with 91 percent of the State's physicians participating. There has been an 11 percent net gain of physicians serving Medicaid patients after implementation of OHP. Physicians who do not participate cite low reimbursement, administrative hassles and having enough patients as the most important reasons why they do not participate in Medicaid. Physicians' interaction with Medicaid plans compares well to those the with other plans. Communication between physicians and OMAP could be improved.
- Community Health Centers: By eliminating cost-based reimbursement under Medicaid and enabling increased competition from private providers, OHP brought several challenges to community-based providers who traditionally serve low-income populations. Analysis of financial and patient population data from seven of the State's twelve federal grantee centers, however, reveals that six of the seven have done reasonably well under OHP. They have enjoyed increases in demand, have made needed investments, improved their efficiency and kept their overall margins stable. The seventh center, Multnomah County Health Department (MCHD, by far the State's largest), has not fared as well. MCHD did not enjoy increased demand, charges per user and per encounter increased and

operational efficiency stagnated. In addition, MCHD made huge increases in their administrative staff relative to the other centers, presumably because of their sponsorship of an OHP managed care plan, CareOregon.

Costs and Financing

- Prior to OHP, Oregon's growth trends in total Medicaid cost, cost per eligible, administrative cost per eligible and total enrollment were similar to those observed in the nation as a whole. After OHP implementation, these trends diverged, with Oregon growth rates exceeding national growth rates in all four areas. The relatively higher growth trends in total cost and number of eligibles in Oregon is partly due to the eligibility expansion.